Proposed Stroke Regulations Discussion Points
November 17, 2009

Proposed Stroke Regulation	Comments received	Change/Rationale	Discussion Issue
Section 1 - General Standards for Stroke Center Designation			
1. Page 2:(C)2.-Continuing education for stroke call roster E. Level I - 10 hours continuing education every year F. Level II - 8 hours every year G. Level III & IV 8 hours every other year	• Too many hours, too costly	• Clarified language • Recommend that hours stay the same o Corresponds with recommendations made by Brain Attack Coalition (BAC)[1] recommendations o Consensus from work group discussions o Eliminated requirement for annual conference attendance for Level III & IV facilities.	• Should requirements be changed?
2. Page 3. (D) Stroke Medical Director requirements	• Recommended that neurologist not required at level II	• Work group discussions has broadened language for allowances for Level II Medical Director--"board certified or board admissible physician with training and expertise in cerebrovascular disease." Grandfather those in position at time regulations go into effect	• Verify that modification acceptable
3. Page 4. (E) Stroke program manager/coordinator-continuing education requirements 2. Level I - 10 hours/year 3. Level II - 8 hours/year 4. Level III & IV - 8 hours every other year	• Too many hours, too costly	• Clarified language, made language more consistent with STEMI regulations. Do not require managers to attend national, state or regional conference at Level III and IV facilities. • Recommend that hours stay the same, same rationale as outlined in Item number 1.	• Are changes acceptable?
4. Page 5. (K) Rehabilitation Consult	• Allow more time	• Extended time frame to 48 hours as recommended	• Verify that modification addresses recommendation.
5. Page 6. (P) Diversion Protocol		• DHSS made consistent with other language	
Section 2- Medical Staffing Standards			
6. Page 6, 5. Emergency Department	• Don't require specialty training in emergency medicine	• DHSS made change since there are multitude of routes to become ED physician and hospital can assure credentials	
7. Page 6, 7. Hospitalist (IV)	• Don't specify physician type	• DHSS removed example	
Section 3 - Hospital Resources and Capabilities			
8. Page 7, (B) & (C) Emergency Department Physician	• Too many CMEs	• Decreased CMEs Level I & II - 6 hours/year[2] Level III & IV - 6 hours every other year • Same continuing education changes for RNs • Separated requirement for 24 hour availability from CME requirement to clarify	• Does group agree with DHSS changes?

Proposed Stroke Regulation	Comments received	Change/Rationale	Discussion Issue
9. Page 7, ED equipment and Page 10 (E) Operating room equipment		• Clarified language. Changed: Thermal control equipment for patients, ~~parenteral fluids and blood~~ and resuscitation fluids~~,~~	
10. Page 10, (G) 5.--added blood bank or access provision for Level IV hospitals	• Change made to align to Trauma Center-Level IV recommendations	• DHSS made change	
Definitions			
11. Page 3, (II) Telemedicine	• Recommended definition from American Telemedicine Association	• Adapted language from Association's webpage definitions	• Does group agree with DHSS adaptation?
General Comments			
12. Joint Commission-Primary Stroke Center (PSC) linkage with Level II Stroke Centers	• Recommendation to fully align PSC with Level II Stroke Center Designation Standards	• DHSS has compared the PSC certification standards to Level II standards and found them generally in alignment • The work group has aligned Missouri standards with PCS standards. • Differences occur due to need to provide clear standards in Missouri regulations against which centers are evaluated. PSC Certification process focuses on general policy and process issues. For example, Missouri reviewers look at specific amount and type of continuing education conducted whereas the Joint Commission reviewers assure that there is a process in place to assure that stroke staff receive stroke education. Missouri standards are from BAC. • DHSS would be happy to meet with representatives from the 11 PSC in Missouri if further discussion is needed.	• Are there any specific recommendations needed for the regulations to better align with Joint Commission standards?
13. Number of Levels of Stroke Centers	• AHA recommends 2 levels-receiving and referring • Some recommend 3 levels	• Group consensus is reflected in the four levels, which generally translates to two levels of receiving hospitals and two levels of referring hospitals.	• Does group affirm current four levels?
14. General vs. specific	• Some want more specific detail--some want less detail	• DHSS worked for appropriate balance and made modifications in the 11/17/09 version where core standards were not compromised	

[1] Brain Attack Coalition (BAC) - comprehensive stroke centers (AHA/ASA 2005); Primary Stroke Centers (JAMA: 283(23) 2000)

[2] Schumacher, et al (2007) Annals of Emerg Med. 50(2)99-107--Provides insight regarding why current tPA administration rates are so low. In addition to patients presentation after the optimum window also referenced the American Academy of Emergency Physician Work Group's statement that there may be lack of belief in tPA efficacy on part of medical community. Also summarized that there were a large number of hospitals and physicians with no experience with t-PA